APPLICATION FOR MEDIATION OR HEARING — FORM C

Michigan Department of Licensing and Regulatory Affairs
Workers' Compensation Agency
PO Box 30016, Lansing, MI 48909

Submitted on behalf of ☐ Insurance Company   ☐ Self-Insured Employer   ☐ Attorney   ☐ Other

Name of Employee (Last, First, MI)	Social Security Number	Date of Birth	
Employee Street Address	City	State	ZIP Code
Name of Employer	County of Injury	Federal ID Number (if known)	
Employer Street Address	City	State	ZIP Code
Date(s) of Injury			

☐ **Add other employer and date(s) of injury**

Name of Employer to be Added	County of Injury	Federal ID Number (if known)	
Street Address	City	State	ZIP Code

Date(s) of injury to be added		INSURANCE CARRIER (DO NOT FILL IN)	
1.	2.	1.	2.
3.	4.	3.	4.

☐ **Petition to stop weekly benefits** *(Provide explanation below and attach affidavit of payment)*	☐ **Petition to fix fees** *(Provide explanation below)*
☐ **Petition to recoup** *(Provide explanation below)*	☐ **Add Funds** *(Specify name of Fund and provision of Act below)*
☐ **Petition to determine rights; e.g., dependency, AWW, etc.** *(Specify below)*	☐ **Other** *(Provide a brief explanation of the issues below)*
☐ **Non-cooperation with vocational rehabilitation** *(Provide explanation below)*	

Name of Party Submitting Form			NAIC or Self-Insured Number (if applicable)	
Street Address			Name of Attorney (if applicable)	
City	State	ZIP Code	Attorney ID Number **P-**	Date
Name of Preparer (Please print)		Signature of Preparer		Telephone Number

WC-104C (Rev. 2/12)